CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, person, partnership, corporation, or association that is certified by the Centers for Medicare and Medicaid Services (CMS) and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

All providers of services must be enrolled in the Medicaid Program on the date services are provided to Medicaid recipients. This chapter contains copies of provider agreements. All providers must sign the Participation Agreement and return it to the First Health Services-Provider Enrollment Unit; an original signature of the individual provider is required. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

Upon receipt of the above information, DMAS assigns a provider number to each approved provider. All claims and correspondence submitted to Medicaid must contain this number.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing, calling, or faxing the request to

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Note: Certification by the Virginia Department of Health does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify First Health Services-Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted to First Health Services-Provider Enrollment Unit.

- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.

- Ensure the recipient's freedom to reject medical care and treatment.

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party.

- Accept Medicaid payment from the first day of eligibility if the provider was aware that application for Medicaid eligibility was pending at the time of admission.

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

- Accept assignment of Medicare benefits for eligible Medicaid recipients.

- Use Program-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

  Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section regarding documentation for medical records.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold confidential and use for authorized Program purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

DMAS provides coverage for physical rehabilitative services under two major programs: physical therapy and related services (physical and occupational therapies and speech-language pathology services) and intensive rehabilitative services. Physical therapy and

related services may be provided by acute care inpatient hospitals, rehabilitation agencies, home health providers, outpatient hospitals, and in Comprehensive Outpatient Rehabilitation Facilities (CORFs). Intensive rehabilitation services may be provided by rehabilitation hospitals and rehabilitation units of acute care hospitals.

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs outline special participation conditions for rehabilitation providers.

Rehabilitation Facilities - Inpatient

DMAS covers intensive rehabilitation services in rehabilitation hospitals and in rehabilitation units of acute care hospitals. To become a provider in this category, the facility must:

- Be certified by HCFA as a rehabilitation hospital, and
- Enter into and have in effect a separate agreement as a Medicaid provider of rehabilitation services.

A copy of the agreement for rehabilitation hospitals is provided at the end of Chapter II.

Rehabilitation Facilities - Outpatient

DMAS covers intensive Comprehensive Outpatient Rehabilitation Facilities (CORFs) or outpatient units associated with hospitals under the conditions listed below. To become a provider in this category, the facility must:

- Submit proof of Medicare certification as a rehabilitation facility, or
- Be administered by a rehabilitation hospital, or
- Be administered by an exempted rehabilitation unit of an acute care hospital which is certified and participating in Medicaid, and
- Enter into and have in effect a separate agreement as a Medicaid provider of rehabilitation services.

A copy of the agreement for outpatient rehabilitation facilities is provided at the end of Chapter II.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT OF 1973

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for handicapped individuals in their program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

CERTIFICATION AND RECERTIFICATION

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order many health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice. For MEDALLION recipients, there must be a referral for the service from the MEDALLION Primary Care Physician (PCP). This referral may be obtained in writing or orally and must be documented in the recipient's record. For specific documentation and program requirements for rehabilitation facilities, see Chapters IV and VI of this manual.

Certifications and recertifications must be signed by the physician responsible for the case, by another physician having knowledge of the care who is authorized to sign by the responsible physician, or by the medical staff.

DOCUMENTATION OF RECORDS

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are required documentation for medical records:

- The record must identify the patient on each page.
- The responsible licensed participating provider must sign and date the entries. The responsible licensed participating provider must countersign care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the progress being made, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written as required for the provider type.

For other record documentation requirements, see Chapter VI.

UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits is discussed below. Medicaid is the payer of last resort.

Workers' Compensation

Items and services, to the extent that payment has been made or can reasonably be expected to be made under the workers' compensation laws of Virginia, are not reimbursable by the Virginia Medicaid Program.

Other Health Insurance

When a recipient has other health insurance such as Trigon or Medicare, Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

Liability Insurance for Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Virginia Code. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the recipient reports a third-party responsibility (other than those cited on the Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the Home Health provider is requested to forward the DMAS-1000 to:

Third- Party Liability Unit
Department of Medical Assistance Services
600 East Broad, Suite 1300
Richmond, Virginia 23219

A copy of this form is provided in the Exhibits section following this chapter.

ASSIGNMENT OF BENEFITS

If a Virginia Medicaid recipient is the holder of an insurance policy that assigns benefits directly to the patient, the Home Health provider must require that benefits be assigned to the Home Health provider (or the hospital if the Home Health provider is hospital-based), or refuse the request for the itemized bill that is necessary for the collection of benefits.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination must be made to the Director, Department of Medical Assistance Services and the First Health Services– Provider Enrollment Unit.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to § 32.1-313.1 of the Code of Virginia. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State-Operated Provider

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, an informal appeal, and a formal appeal. The provider will have 30 days to submit information for written reconsideration and will have

30 days' notice to request an informal appeal. If there is an adverse decision the provider has 30 days from the decision date to request a formal appeal.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia) and the State Plan for Medical Assistance provided for in § 32.1-325.1 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse actions such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid Program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state-operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include: the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his or her designee will review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. Currently, dissemination of this information is accomplished through the DMAS website, as well as, with regard to certain publications, by mailing such publications directly to providers, keyed to the provider number on the enrollment file. For publications that are mailed to providers, this means that each assigned provider receives program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of such publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

(See the "Exhibits" section at the end of the chapter for a sample of the form.)

Copies of manuals, manual updates, and certain other publications are available on the DMAS website (www.dmas.state.va.us). If you do not have access to the Internet, please contact DMAS' mailing contractor, Commonwealth Martin, at 804-780-0076.

EXHIBITS

EXHIBITS TABLE OF CONTENTS

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program

Hospital Participation Agreement

If re-enrolling, enter **Medicaid** Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Enter 6-digit **MEDICARE** provider number here→ _____ Check this box if Rehab Hospital→ ☐

1. **The provider is currently licensed and certified under applicable laws of this state. (Check the item which applies to your hospital.)**

   ____ A.) As of _____ (Date) has been fully certified for participation with Title XVIII (Medicare)of Public Law 89-97.

   ____ B.) Is limited to an age group not eligible for Title XVIII benefits, but is as of _____ (Date), accredited by the Joint Commission on Accreditation for Hospitals and has a utilization review plan which meets Title XVIII AND Title XIX standards for utilization review.
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in VMAP.**
3. **The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on 30 (thirty) days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**

11. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

For First Health's use *only*

Director, Division of Program Operations Date

Original Signature of Administrator **Date**

Title

_____City OR _____County of _____

IRS Name (required)

IRS Identification Number **(Area Code) Telephone Number**

Mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

Medicare Carrier and Vendor Number (if applicable)

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Outpatient Rehabilitation Services Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

Enter 6-digit MEDICARE provider number here→ _____ Check this box if you are a CORF→ ☐

1. **The provider is currently licensed and certified under applicable laws of the state as of _____ (Month/Day/Year) and has been fully certified for participation with Title XVIII (Medicare) of Public Law 89-97.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973, 29 USC §794) VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under VMAP constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **The agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*

Director, Division of Program Operations Date

IRS Identification Name (required)

Mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

For Provider of Services:

Original Signature of Provider **Date**

_____City *OR* _____County of _____

IRS Identification Number **(Area Code) Telephone Number**

Medicare Carrier and Vendor Number

First Health
Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105